Medical Assistance Provider Bulletin

Attention: All Title XIX Certified Audiologists and Hearing Aid Dealers

Subject: DRG Implementation, Audiology and Hearing Aid Policy

Date: August 10, 1990

Code: MAPB-090-020-D
MAPB-090-005-HA

Department of Health and Social Services, Division of Health,
Bureau of Health Care Financing, P.O. Box 309, Madison, Wisconsin 53701

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I. IMPLEMENTATION OF THE DRG REIMBURSEMENT SYSTEM FOR INPATIENT HOSPITALS

A. Introduction

In August, 1987, the Wisconsin Department of Health and Social Services (DHSS) was granted authority under s. 49.45(3)(e)3 of the Wisconsin Statutes to reimburse hospitals participating in the Wisconsin Medical Assistance Program (WMAP) on a diagnosis related group (DRG) basis. Medicare is currently reimbursing hospitals under a similar type of payment system.

Effective with dates of discharge on or after January 1, 1991, the WMAP will implement the DRG reimbursement system for WMAP-certified in-state and border status hospitals.

The DRG system, like the WMAP's current prospective payment system, is intended to encourage continued cost-effective hospital treatment. Under the DRG system, however, hospitals will be paid based on each patient's specific diagnosis. As a result, DRG hospital reimbursement will be more equitable by directly responding to changes in the mix of patients the hospital serves.

The costs for certain types of services currently included in the calculation of a rate-per-discharge for some hospitals will no longer be considered allowable hospital costs. This is necessary in order to establish statewide DRG rates. Consequently, the WMAP can include in the rate calculations only those services which nearly all hospitals have in common.

B. Certification under DRGs

As the WMAP moves to implement a DRG payment system, we find it necessary to clarify what services are considered inpatient hospital services and what services are considered "professional services." Professional services, which include audiology and hearing aid dealer services, will not be included in the DRG payment to the hospital and must be separately billed to the WMAP. Any audiologist or hearing aid dealer providing these services must be individually certified by the WMAP.

Certification effective dates with the WMAP are assigned based on the date of application. Therefore, certification should be obtained as soon as possible, because there will be no reimbursement under DRGs for audiology and hearing aid dealer services provided to recipients whose date of discharge is on or after January 1, 1991, regardless of the date of admission of the recipient.

To obtain certification materials, please contact:

EDS
Attn: Provider Maintenance
6406 Bridge Road
Madison, WI 53784-0006

C. Billing under DRGs

Effective with dates of discharge on or after January 1, 1991, hospitals will no longer be allowed to include audiology and hearing aid dealer services, provided to a hospital inpatient, as billable services on the UB-82 claim form, as these are professional services. Any audiologist or hearing aid dealer providing these services to a hospital inpatient must be billed on the HCFA 1500 claim form.

In order to allow reimbursement for audiology and hearing aid dealer services provided to a hospital inpatient who may not be discharged until on or after January 1, 1991, the WMAP is changing current policy to allow all audiology and hearing aid dealer services with dates of service on or after July 1, 1990, to be billable with place of service 1 (inpatient hospital).

Refer to Attachments 4 and 5 for an updated list of allowable place of service (POS) and type of service (TOS) codes for audiologists and hearing aid dealers for dates of service on or after July 1, 1990. These replace Attachments 3 and C-5 from Medical Assistance Provider Bulletins dated June 15, 1989 (MAPB-089-019-D/004-HA) and September 1, 1987 (MAPB-087-015-D/087-002-HA).

D. PA for Audiology Services under DRGs

Effective with dates of service on or after July 1, 1990, the WMAP has eliminated the prior authorization requirement for procedure codes 92581 (evoked response audiometry) and 92585 (brain-stem evoked response recording) when the services are provided to a hospital inpatient (place of service 1).

II. ADDITIONAL COVERAGE OF HEARING AID SERVICES AND SUPPLIES: ASSISTIVE LISTENING DEVICES (ALDs)

A. Criteria for WMAP Coverage of ALDs

Effective with dates of service on or after July 1, 1990, the WMAP will reimburse providers for ALDs. Although there are numerous items on the market that are described as assistive listening devices, the WMAP coverage of ALDs is limited to those which meet all of the following criteria:

- the system is portable
- the system is battery operated (disposable battery)
- the ALD has one or two hearing aid receivers (monaural or binaural earphones) with single or Y-cord
- the ALD has a standard amplifier

B. Prior Authorization and Billing Information

Providers must obtain prior authorization from the WMAP before dispensing an ALD. The prior authorization forms required are the PA/OF, PA/ARF1, and PA/ARF2. Use procedure code W6902 and TOS P to request prior authorization and bill for an ALD. The WMAP will not reimburse providers for the rental of an ALD, only for the purchase.

Like a hearing aid, an ALD must be billed on the HCFA 1500 claim form with a claim sort indicator of D. ALDs, however, should be billed at the provider's usual and customary fee and will be reimbursed at the lesser of the provider's usual and customary charge or the WMAP's maximum allowable fee. The required recipient copayment amount is $3.00. There will be no dispensing fee for ALDs.

Please refer to Medical Assistance Provider Bulletin (MAPB-087-015-D/087-002-HA) dated September 1, 1987, for instructions to complete the prior authorization forms and the HCFA 1500 claim form.

C. Batteries for ALDs

The WMAP will not be adding a separate code for 9 volt or AA batteries (the battery used in most ALDs). Instead, batteries for ALDs should be billed under procedure code W6923 (zinc carbon - standard) and W6935 (zinc carbon - binaural). The reimbursement rates for these two codes have been adjusted accordingly.

III. ADDITIONAL CODES BILLABLE BY AUDIOLOGISTS

Effective with dates of service on or after July 1, 1990, WMAP-certified audiologists may be reimbursed by the WMAP for a complete electronystagmographic (ENG) evaluation. This is a change from current WMAP policy, which allows audiologists to perform the complete battery of tests associated with an ENG evaluation but reimburses only a portion of the evaluation (procedure codes 92542, positional nystagmus test, and 92543, caloric vestibular test).

Listed below are the additional procedure codes and their descriptions:

Procedure Code	Description
92541	Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording
92544	Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording
92545	Oscillating tracking test, with recording
92546	Torsion swing test, with recording

Procedure Code	Description
92547	Use of vertical electrodes in any or all of above tests counts as one additional test.

The valid TOS code is B, which must be indicated in element 24G of the HCFA 1500 claim form.

Please see Attachment 1 for the complete list of codes billable by audiologists for dates of service on or after July 1, 1990.

IV. UNLISTED HEARING AID SUPPLIES AND SERVICES

The WMAP has developed a new procedure code to be used when requesting unlisted hearing aid supplies or services. And if the provider cannot find an appropriate code among the WMAP covered services listed in the Medical Assistance Provider Bulletin (MAPB-087-015-D/087-002-HA) dated September 1, 1987. The new code, W6999, (unlisted hearing aid supplies/service), type of service P, will require prior authorization. The effective date for use of this code is July 1, 1990.

V. PHYSICIAN OTOLOGICAL REPORT FOR HEARING AID EVALUATION

Effective with dates of service on or after July 1, 1989, limited hearing evaluations and hearing aid checks are included as allowable hearing aid dealer services, for adults, age 22 and over, who are not cognitively or behaviorally impaired. This provision has recently been incorporated in the permanent rules of the Department of Health and Social Services.

The Physician Otological Report for Hearing Aid Evaluation (PA/OF) has been revised to allow the prescribing physician to appropriately refer the patient to either an audiologist or hearing aid dealer. The new item 7 on the PA/OF form concerning hearing aid dealer or audiologist referral must be completed. The PA/OF forms are available from the following address:

EDS
Attn: Claim Reorder
6406 Bridge Road
Madison, WI 53784-0003

Please refer to Attachments 2 and 3 of this bulletin for a sample PA/OF and completion instructions.

VI. CHANGES IN LIMITATION OF HEARING AID ACCESSORIES

Currently all hearing aid accessories for all recipients are limited to one per recipient per year. Effective with dates of service on or after July 1, 1990, the limit on hearing aid accessories is changed as indicated below.

1. Recipients age 18 and under: three earmolds per hearing aid, two single cords per hearing aid and two Y-cords per recipient per year;

2. Recipients over age 18: one earmold per hearing aid, one single cord per hearing aid and one Y-cord per recipient per year; and

3. All recipients: one harness, one CROS fitting, one new receiver and one bone-conduction receiver with headboard per recipient per year.

VII. HEARING AID PERFORMANCE CHECKS

As a reminder, a hearing aid performance check (an evaluation of user benefit, including functional gain and aided speech audiometrics, with the hearing aid provided to the client) is required after a new or replacement hearing aid has been worn for a 30-day trial period. The hearing aid dealer should advise the recipient to return within thirty days of receiving the hearing aid for a hearing aid performance check.

The hearing aid performance check should include an objective (i.e., electroacoustic measurements) or a subjective evaluation of the hearing aid (e.g., the recipient's and/or hearing aid dispenser's statement of satisfactory performance).

Reimbursement for dispensing a hearing aid will be made only after the performance check has shown the hearing aid to be satisfactory, or after 45 days has elapsed from the date of service with no response from the recipient.

VIII. LATE BILLING REMINDER

Providers are reminded that federal regulations require that all claims be submitted, correct and complete, within one year of the date of service. The only exceptions to this requirement, and the required documentation and procedures, are identified in Section IV-F of Part A of the WMAP Provider Handbook.

IX. PAPERLESS CLAIMS

Submit your claims <u>electronically</u>. Experience shows that electronic billers get quicker results with fewer errors than conventional paper billers. EDS offers <u>free</u> software and consultation services to get you started right. Simply fill out Attachment 6 of this bulletin and mail it to EDS, or call (608) 221-4746 and ask for the Electronic Media Claims (EMC) Unit.